Royal College of Nursing

Safeguarding Children and Young People – Every Nurse's Responsibility

RCN guidance for nursing staff

CLINICAL PROFESSIONAL RESOURCE

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Leila Francis RGN, RSCN, MSc, BSc (Designated Nurse Safeguarding Children, NHS Mid Essex Clinical Commissioning Group)

Members of the RCN's Children and Young People Staying Healthy Forum

Fiona Smith, Professional Lead for Children and Young People's Nursing, Royal College of Nursing (RCN), London (until January 2021)

Peta Clark, Professional Lead for Children and Young People's Nursing, Royal College of Nursing (RCN), Sunderland

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This document has been designed in collaboration with our members to ensure it meets most accessibility standards. However, if this does not fit your requirements, please contact **corporate.communications@rcn.org.uk**

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Introduction

This Royal College of Nursing (RCN) guidance is for all nursing staff and not just those whose work focuses on safeguarding children. All nurses who are in contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding/child protection issues. This responsibility also applies to nurses working primarily with adults. Staff in these settings need to be aware that any adult may pose a risk to children due to their health or behaviour. Even if your primary responsibility does not relate to children, you will have the opportunity to observe and identify behaviour which could indicate a child is being abused or neglected.

There is no single law that defines the age of a child across the UK. England, Wales, Northern Ireland and Scotland each have their own guidance setting out the duties and responsibilities of organisations to keep children safe, but all agree that child protection legislation and guidance applies to children until they reach their 18th birthday. In this publication, the term 'children and young people' applies to anyone who has not yet reached their 18th birthday.

Child welfare concerns may arise in many different contexts and can vary greatly in terms of their nature and seriousness. Children may be abused in a family, institutional or community setting, by those known to them or by a stranger, including via the internet. In the case of female genital mutilation (FGM), children may be taken out of the country. They may be abused by an adult or adults, or another child or children. An abused child will often experience more than one type of abuse, as well as other difficulties in their lives. Abuse and neglect can happen over a period of time but can also be a one-off event. Child abuse and neglect can have a major long-term impact on all aspects of a child's health, development and well-being.

This publication is not comprehensive but does highlight the issues that will help you recognise the possible signs of abuse. It also offers guidance on when, and how, you should seek further information, training, support and advice from your organisation/ employer. Please also refer to the Department for Education's *What to do if you're worried a child is being abused: Advice for practitioners* (2015a).

Learning from experience

Safeguarding and child protection requires a complex multi-agency system with many different organisations and individuals playing their part. Reviewing how well the system is working is crucial if we are to improve outcomes for children and their families.

When a child is seriously harmed or dies as a result of abuse or neglect, a review may be conducted to identify ways that professionals and organisations can improve the way they work together to safeguard children and prevent similar incidents from occurring. Each UK country has its own terminology and guidance for carrying out and sharing the learning from the reviews. Cases that meet the criteria set out in the relevant guidance are reviewed by multi-agency panels.

The reviews are known as:

- child safeguarding practice reviews in England
- case management reviews in Northern Ireland
- significant case reviews in Scotland
- child practice reviews in Wales.

All four UK countries have a process of producing composite learnings from reviews. The National Society for the Prevention of Cruelty to Children (NSPCC) produce thematic briefings to highlight the learning from case reviews that are conducted when a child dies or is seriously injured, and abuse or neglect are suspected.

Each briefing focuses on a different topic, pulling together key risk factors and practice recommendations to help practitioners understand and act upon the learning from case reviews. Specific **briefings for health practitioners** can be accessed via the NSPCC website.

Child maltreatment – the facts

If a child is considered to be suffering, or likely to suffer, significant harm the local authority will make them the subject of a child protection plan (in England) or add them to a child protection register (in Northern Ireland, Scotland and Wales).

The number of children on child protection registers or subject to a child protection plan on 31 March 2019 (or 31 July in Scotland)

Nation	2015	2016	2017	2018	2019
England	49,690	50,310	51,080	53,790	52,260
Scotland	2,741	2,715	2,600	2,668	2,820
Wales	2,935	3,060	2,805	2,960	2,599
Northern Ireland	1,969	2,146	2,132	2,082	2,211
UK total	57,335	58,231	58,533	61,500	59,890

NSPCC Learning (2020) *Child protection plan and register statistics: UK 2015–2019*. June. London: NSPCC.

Definition and key principles of safeguarding children

The UK's four nations – England, Northern Ireland, Scotland and Wales – each have their own child protection system and laws to help protect children from abuse and neglect. Although the child protection systems are different in each nation, they are all based on similar principles.

England

The Department for Education (DfE) is responsible for child protection in England. It sets out policy, legislation and statutory guidance on how the child protection system should work. Local safeguarding partnerships are responsible for child protection policy, procedure and guidance at a local level. The local safeguarding arrangements are led by three statutory safeguarding partners:

- the local authority
- the clinical commissioning group
- the police.

Northern Ireland

The Northern Ireland Executive, through the Department of Health, is responsible for child protection in Northern Ireland. It sets out policy, legislation and statutory guidance on how the child protection system should work. The Safeguarding Board for Northern Ireland (SBNI) co-ordinates and ensures the effectiveness of work to protect and promote the welfare of children. The board includes representatives from health, social care, the police, the probation board, youth justice, education, district councils and the NSPCC. The SBNI is responsible for developing policies and procedures to improve how different agencies work together.

Scotland

The Scottish Government is responsible for child protection in Scotland. It sets out policy, legislation and statutory guidance on how the child protection system should work. Child Protection Committees (CPCs) are responsible for multi-agency child protection policy, procedure, guidance and practice. Within each local authority, CPCs work with local agencies, such as children's social work, health services and the police, to protect children.

Wales

The Social Services and Well-being (Wales) Act 2014 came into force in April 2016. It provides the legal framework for social service provision in Wales. At a local level, regional safeguarding children boards co-ordinate and ensure the effectiveness of work to protect and promote the welfare of children. They are responsible for local child protection policy, procedure and guidance. Each board includes any:

- local authority

- chief officer of police
- local health board
- NHS trust
- provider of probation services that falls within the safeguarding board area.

Definition

Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best outcomes (Department of Education, 2018).

Effective safeguarding arrangements in every local area should be underpinned by two key principles:

1. safeguarding is everyone's responsibility – for services to be effective each professional and organisation should play their full part
2. a child-centred approach – for services to be effective they should be based on a clear understanding of the needs and views of children.

This child-centred approach is fundamental to safeguarding and promoting the welfare of every child. A child-centred approach means keeping the child the main focus when making decisions about their lives and working in partnership with them and their families.

Terminology

Child protection is part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

Abuse is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family, institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children.

Contextual safeguarding – developed by Dr Carlene Firmin at the University of Bedfordshire's Contextual Safeguarding Network – this recognises that as young people grow and develop, they are influenced by a whole range of environments and people outside of their family. For example, in school or college, in the local community, in their peer groups or online. Children and young people may encounter risk in any of these

environments. Sometimes, the different contexts are inter-related and can mean that children and young people may encounter multiple risks. Contextual safeguarding looks at how we can best understand these risks, engage with children and young people, and help to keep them safe. It is an approach that has often been used to apply to adolescents, though the lessons can equally be applied to younger children, especially in today's changing world.

Complex safeguarding is an approach and term emerging from Greater Manchester (GM). It articulates GM's recognition that the current child protection system, legislation and practice does not adequately address the extra-familial harm and risk facing many young people. Complex safeguarding is a term that has been applied to encompass a range of safeguarding issues that adolescents face, in particular, those related to criminality and exploitation. The definition of complex safeguarding is:

> 'Criminal activity (often organised), or behaviour associated to criminality, involving vulnerable children/young people, where there is exploitation and/or a clear or implied safeguarding concern.' (Manchester Safeguarding Partnership, 2020)

This includes, but is not limited to, Child Criminal Exploitation (CCE), County Lines, Modern Slavery including Trafficking and Child Sexual Exploitation (CSE).

Why are children vulnerable?

Abuse can happen to anyone, but research shows that some children who have experienced abuse share similar characteristics. This means they may be more vulnerable. Having one or more of these characteristics does not automatically mean a child will experience abuse or neglect – and not having any of them is not a guarantee that a child will never be harmed. However, we do know that these challenges are often interlinked and the more problems a child and their family are experiencing, the greater the risk of abuse (Cleaver, Unell & Aldgate, 2011). It is important for professionals to understand risk and vulnerability factors so they can identify which families need extra support to help keep their children safe.

Children may be more vulnerable if they:

- are living in a chaotic or dysfunctional household (including parental substance use, domestic abuse, parental mental health issues, parental criminality)
- have a history of abuse (including familial child sexual abuse, risk of forced marriage, risk of honour-based violence, physical and emotional abuse and neglect)
- have suffered a recent bereavement or loss
- have a gang/County Lines association – either through relatives, peers or intimate relationships. (County Lines is a term used when drug gangs from big cities expand their operations to smaller towns, often using violence to drive out local dealers and exploiting children and vulnerable people to sell drugs. These dealers will use dedicated mobile phone lines, known as 'deal lines', to take orders from drug users)
- are attending school with young people who are sexually exploited
- have a learning disability
- are unsure about their sexual orientation or unable to disclose sexual orientation to their families
- are friends with young people who are sexually exploited
- are homeless
- are lacking friends from the same age group
- are living in a gang neighbourhood
- are living in residential care
- are living in hostel, bed and breakfast accommodation or a foyer
- have low self-esteem or self-confidence
- are a young carer
- are an unaccompanied asylum-seeking child (UASC – defined as an individual who is under 18, has arrived in the UK without a responsible adult, is not being cared for by an adult who, by law or custom, has responsibility to do so, is separated from both parents and has applied for asylum in the UK in his/her own right).

Think family

Families have a range of needs and, from time to time, will require support or services to help meet them. Difficulties that impact on one family member will inevitably have a knock-on effect on other family members. For this reason, all practitioners should 'think family'. In a system that 'thinks family', both adult and children's services should:

- have no wrong door – help should be accessible no matter how the family tries to access it
- look at the whole family
- build on family strengths
- provide support tailored to need.

Individual practitioners working with children or adults (or both) should:

- ensure they know who has parental responsibility
- ensure they know who is living with the child/children
- consider the involvement, potential contribution and (when appropriate) the risks associated with all the adults who have a significant influence on a family, even if they are not living in the same house, or are not formally a family member
- have ready access to information to enable themselves and other practitioners to consider the impact of a parent's/carer's condition, behaviour, family functioning and parenting capacity
- identify and provide responsive services for families that are family focused.

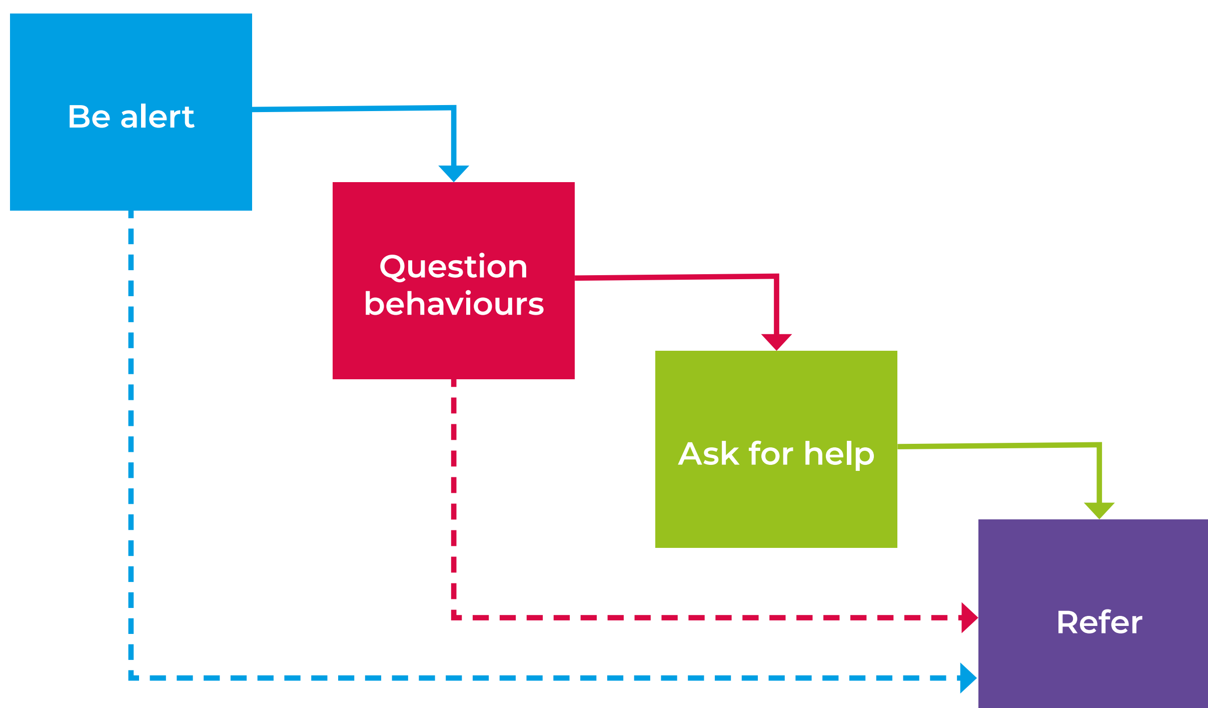
Signs/indicators of child abuse and neglect

All nursing staff need to be able to identify potential signs of child abuse:

- Physical signs such as hand-slap marks, bruising in unusual areas, bruised eyes, bite marks.
- Poor physical care and inadequate hygiene, inappropriate dress or failure to seek appropriate health care/repeated missed appointments/cancellations and failed access visits.
- Unrealistic parental expectations and over protection of a child.
- Poor school attendance not justified on health (including mental health) grounds.
- A child's behaviour may indicate that they have been abused. The child may show fear of adults or a fear of certain adults when they approach them, display aggressive behaviour or deliberate self-harm and substance abuse).
- The story provided by the adult might be inconsistent with any injuries.
- The child may have repeatedly attended a health care organisation with different types of injuries in a short period of time or presented in a variety of health care settings.

There are four key steps to follow to help you to identify and respond appropriately to possible abuse and/or neglect (see Figure 1).

Figure 1: Four key steps to identify abuse and/or neglect (HM Government, 2015c)



Some of the following signs might be indicators of abuse or neglect:

- behaviour changes – they may become aggressive, challenging, disruptive, withdrawn or clingy, or they might have difficulty sleeping or start wetting the bed
- clothes which are ill-fitting and/or dirty
- consistently poor hygiene
- making strong efforts to avoid specific family members or friends, without an obvious reason
- not wanting to change clothes in front of others or participate in physical activities
- having problems at school, for example, a sudden lack of concentration and learning or appearing to be tired and hungry
- talking about being left home alone, with inappropriate carers or with stranger
- reaching developmental milestones late, such as learning to speak or walk, with no medical reason
- regularly missing from school or education
- reluctant to go home after school
- poor school attendance and punctuality, or consistently late being picked up
- drinking alcohol regularly from an early age
- concerned for younger siblings without explaining why
- talking about running away
- shying away from being touched or flinching at sudden movement
- parents who are dismissive and non-responsive to practitioners' concern
- parents who collect them from school when drunk, or under the influence of drugs.

There is no one definitive sign, symptom or injury. A series of seemingly minor events can be just as damaging as any one event. The NICE clinical guideline When to suspect child maltreatment in under 18s sets out the alerting features of maltreatment and is a key tool to help identify it (NICE, 2017).

Physical abuse

Physical abuse is deliberately physically hurting a child. It might take a variety of different forms, including hitting, pinching, shaking, throwing, poisoning, burning or scalding, drowning or suffocating a child. Physical abuse can happen in any family, but children may be more at risk if their parents have problems with drugs, alcohol and mental health, or if they live in a home where there is domestic abuse. Babies and disabled children also have a higher risk of suffering physical abuse. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child. Physical abuse can also occur outside of the family environment.

The following signs may be indicators of physical abuse:

- frequent injuries
- unexplained or unusual fractures or broken bones
- unexplained bruises or cuts, burns or scalds, bite marks.

Emotional abuse

Emotional abuse is the persistent emotional maltreatment of a child, such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them, or making fun of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

Emotional abuse also includes seeing or hearing the ill-treatment of another (for example, domestic abuse). It includes serious bullying (for example, cyber bullying), causing children to feel frightened or in danger frequently, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Some of the following signs may be indicators of emotional abuse:

- children who are excessively withdrawn, fearful, or anxious about doing something wrong
- parents or carers who withdraw their attention from their child, giving the child a 'cold shoulder'
- parents or carers blaming their problems on their child
- parents or carers who humiliate their child, for example, by name-calling or making negative comparisons.

Sexual abuse and exploitation

Sexual abuse is any sexual activity with a child. You should be aware that many children and young people who are victims of sexual abuse do not recognise themselves as such. A child may not understand what is happening and may not even understand that it is wrong. Sexual abuse can have a long-term impact on mental health.

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually

inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males, women can also commit acts of sexual abuse, as can other children.

Some of the following signs may be indicators of sexual abuse:

- knowledge or interest in sexual acts inappropriate to a child's age
- using sexual language or having sexual knowledge that you wouldn't expect them to have
- asking others to behave sexually or play sexual games
- physical sexual health problems, including soreness in the genital and anal areas, sexually transmitted infections or underage pregnancy.

Child sexual exploitation is a form of child sexual abuse. It occurs when an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity, either in exchange for something the victim needs or wants, and/or for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur using technology.

Some of the following signs may be indicators of sexual exploitation:

- unexplained gifts or new possessions
- associating with other young people involved in exploitation
- having older boyfriends or girlfriends
- suffering from sexually transmitted infections or being pregnant
- changes in emotional well-being
- drugs and alcohol misuse
- missing for periods of time or regularly coming home late
- regularly missing school or education or not taking part in education.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate caregivers)
- ensure access to appropriate medical care or treatment

- be responsive to a child's basic emotional needs.

Some of the following signs may be indicators of neglect:

- living in a home that is indisputably dirty or unsafe
- left hungry or dirty
- left without adequate clothing (for example, not having a winter coat)
- living in dangerous conditions (for example, around drugs, alcohol or violence)
- often angry, aggressive or self-harming
- not receiving basic health care
- parents not seeking medical treatment when their children are ill or are injured.

Children who miss health care appointments

Children have the right to access the health care that they need to attain optimal health and well-being. Parents/carers have a responsibility to ensure that their child's health needs are met, and this includes bringing them to/ensuring they access health appointments.

The link to poor outcomes is widely recognised for children who are not brought or supported to attend health appointments and this may be considered to be a child protection matter. All organisations should have a policy in place to manage situations where children are not brought to health appointments and to ensure their wellbeing.

Radicalisation and extremism

Children can be exposed to different views and receive information from various sources. Some of these views may be considered radical or extreme. Radicalisation is the process through which a person comes to support, or be involved in, extremist ideologies. It can result in a person becoming drawn into terrorism and is a form of harm.

Extremism goes beyond terrorism and includes people who target the vulnerable (including the young) and seek to:

- sow division between communities on the basis of race, faith or denomination
- justify discrimination towards women and girls
- persuade others that minorities are inferior
- argue against the primacy of democracy and the rule of law in our society.

Extremism is defined in the Counter-extremism strategy (HM Government, 2015a) as the:

> 'vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs… We also regard calls for the death of members of our armed forces as extremist.'

Challenging and tackling extremism needs to be a shared effort (HM Government, 2015a). For this reason, some organisations in England, Scotland and Wales have a duty, as a specified authority under section 26 of the Counter Terrorism and Security Act 2015, to identify vulnerable children and young people and prevent them from being drawn into terrorism (HM Government, 2015b). This is known as the Prevent duty. These organisations include schools, registered childcare providers, local authorities, the police, prisons and probation services and NHS trusts and foundations. Other organisations may also have Prevent duties if they perform delegated local authority functions.

Even if your organisation does not have a legal Prevent duty, you should still work to prevent radicalisation and extremism as part of your overall safeguarding responsibilities. There is Prevent duty guidance for specified authorities in England and Wales (Home Office, 2019a) and separate guidance for Scotland (Home Office, 2019b). These detail the responsibilities of organisations in different sectors.

There is no specific Prevent guidance for Northern Ireland. This is explained in sections 11.59–11.6 of the Prevent strategy (HM Government, 2011).

Capacity and consent

People aged 16 or over are entitled to consent to their own treatment. This can only be overruled in exceptional circumstances. Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide their own medical treatment, unless there is significant evidence to suggest otherwise.

Children under the age of 16 can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them. This could be:

- the child's mother or father
- the child's legally appointed guardian
- a person with a residence order concerning the child
- a local authority designated to care for the child
- a local authority or person with an emergency protection order for the child.

Gillick competency and Fraser guidelines – balancing children's rights with the responsibility to keep them safe from harm (NSPCC, 2019)

The Gillick competency and Fraser guidelines help people who work with children to balance the need to listen to children's wishes with the responsibility to keep them safe. An NSPCC factsheet outlines key findings from a 1985 judgement by the House of Lords on a legal case, which looked specifically at whether doctors can give contraceptive advice or treatment to girls under the age of 16 without parental consent. Since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions (NSPCC, 2019).

Liberty Protection Safeguards (LPS)

The new Liberty Protection Safeguards (LPS) came into force in October 2020 via the Mental Capacity (Amendment) Act 2019. The LPS replaces the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive somebody of their liberty. The legislation creates Responsible Bodies to authorise an incapacitated person's deprivation of liberty.

The identity of the Responsible Body depends entirely upon the arrangements for the person's care and can be:

- an NHS trust or local health board (if the person is being cared for in a hospital)
- a clinical commissioning group or local health board for arrangements under NHS Continuing Healthcare
- a local authority in all other situations, such as care homes, supported living and private hospitals.

Under LPS, deprivation of liberty will have to be authorised in advance by the Responsible Body and will also apply to 16-and 17-year olds alongside adults. In relation to this age group:

- legal authorisation must be sought for deprivation of liberty of 16- or 17-year-olds who lack capacity to consent
- public authorities will need to review and potentially seek legal authorisation for the confinement of 16- and 17-year-olds in foster or residential placements to which they lack capacity to consent, where councils have relied on parental consent
- be alert to situations of 'private' confinements of 16- or 17- year-olds in their own homes, or in private schools/colleges, because state imputability arises when the state knows, or ought to know, of such private confinements.

Your role and responsibilities

You should make sure that you understand and work within the local multi-agency safeguarding arrangements that are in place in your area. In doing so, you should be guided by four key principles.

Your role and responsibilities – key principles

1. Children have a right to be safe and should be protected from all forms of abuse and neglect.

2. Safeguarding children is everyone's responsibility.

3. It is better to help children as early as possible, before issues escalate and become more damaging.

4. Children and families are best supported and protected when there is a coordinated response from all relevant agencies.

You should not let other considerations, like the fear of damaging relationships with adults, get in the way of protecting children from abuse and neglect. If you think that referral to children's social care is necessary, you should view it as the beginning of a process of inquiry, not as an accusation.

Core competencies

As a nurse, you must demonstrate the following core competencies.

- Recognise and use professional and clinical knowledge, and understand what constitutes child maltreatment, and be able to identify signs of child abuse or neglect:
    - physical abuse, including fabricated and induced illness, and FGM
    - neglect
    - emotional abuse, forced marriage, modern slavery and grooming, and exploitation to support and/or commit acts of terrorism (known as radicalisation), children who go missing from home or care, County Lines (young people involved in organised crime who are coerced to traffic drugs or other illegal items around the country), and child trafficking (many children and young people are trafficked either within the UK or from other countries like Vietnam, Albania and Romania and then exploited, forced to work or sold.
    - sexual abuse, including child sexual exploitation, missing children, County Lines and child trafficking (internal and external)
    - domestic abuse.
- Able to identify and refer a child suspected of being a victim of trafficking, County Lines, forced marriage, domestic violence, or modern slavery or sexual exploitation; at risk of exploitation/grooming by radicalisers, gang and electronic media abuse.
- Able to identify and refer a child at risk of FGM or having been a victim of FGM.
- Recognise that children with any disability (visible or hidden) are at greater risk of abuse.

- Recognise the vulnerabilities of children who are looked after.
- Act as an effective advocate for the child or young person, proactively seeking the child’s views while taking into consideration the Gillick competency and Fraser guidelines (in Scotland, the Age of Legal Capacity), but also consider how to balance children’s rights and wishes with a professional responsibility to keep children safe from harm.
- Be aware of the potential impact of a parent/carer’s physical and mental health on the well-being and development of a child or young person (including an unborn child), and:
  - the impact of parental substance misuse, domestic violence and abuse
  - the risks associated with the internet and online social networking
  - adverse childhood experiences (ACEs) and their effects.
- Be aware that a child not being brought to a health appointment may be a potential indicator of neglect or other forms of abuse.
- Be aware of the potential significance on the well-being of a child of a parent/carer not attending or changing health appointments, particularly if the appointments are for mental health, alcohol or substance misuse problems (where appropriate to role).
- Take appropriate action if they have concerns, including seeking advice, documenting and reporting/referring concerns safely in accordance with local procedures.
- Document safeguarding/child protection concerns to be able to inform the relevant staff and agencies, as necessary. Maintain appropriate record keeping and differentiate between fact and opinion.
- If you work in an agency that uses a flagging/coding system for children at risk, ensure you are familiar with the system, as appropriate to role.
- Be clear about your own and colleagues’ roles, responsibilities and professional boundaries, including professional abuse and the need to raise concerns about conduct of colleagues if appropriate.
- Act in accordance with key statutory and non-statutory guidance and legislation, including the UN Convention on the Rights of the Child and Human Rights Act (1989).

A child’s welfare is paramount in every respect, regardless of whether you feel sympathy for the parent or carer. You must always act on a child’s behalf if you have concerns. It is important you take action because in some instances, such as children or young people experiencing (or at risk of experiencing) honour-based abuse, forced marriage or FGM, there may only be one opportunity to speak to a victim/potential victim. For children who need help, everyday matters.

Your employer's roles and responsibilities

All health care organisations and health care providers have a duty outlined in legislation, regardless of who the commissioner is, to make arrangements to safeguard and promote the welfare of children and young people, and to co-operate with other agencies to protect individual children and young people from harm. Chief executive officers have a responsibility to ensure that all staff are able to meet this requirement, but all practitioners have a personal duty under their professional codes to maintain their knowledge, skills and competence.

Many providers of health services providing a regulated activity in England, for example, are required to be registered with the Care Quality Commission (CQC). To register, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported. This includes private health care, health care provision in independent schools, voluntary sector providers, online providers, and health care services that do not provide care or treatment to children.

Employer responsibilities are clearly defined both within the law and outlined fully in the Department for Education's *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* (2018). Each provider organisation should have:

- a senior board level lead for safeguarding
- a culture of listening to children
- a named nurse and doctor for safeguarding children (and midwife where there are maternity services) whose contact details are known throughout the organisation
- safeguarding children procedures in place and available across the organisation
- a single, integrated child health record system, including mechanisms for obtaining records of previous attendances/admissions from other organisations
- arrangements set out for the processes of sharing information
- a secure facility for storing records in line with Caldicott requirements
- clearly defined policies on how to raise concerns about colleagues, manage sickness and absence, and review individual performance, including when referral should be made to the NMC
- training, supervision and support for staff.

Specialist safeguarding practitioners

Designated professional (lead child protection professional in Scotland)

The term designated doctor or nurse denotes dedicated professionals with specific roles and responsibilities for safeguarding children, including the provision of strategic advice and guidance to organisational boards across health care services and to local multi-agency safeguarding organisations (formerly local safeguarding children's boards (LSCBs)).

In **England**[1], all clinical commissioning groups are required to have a designated doctor and designated nurse.

In **Northern Ireland**[2], each health and social services trust has designated professionals for child protection.

In **Scotland**[3], there are lead paediatricians and consultant/lead nurses who provide clinical leadership, advice, strategic planning and are members of the child protection committee. In larger health boards, there are child protection nurse advisers who support the lead nurses.

In **Wales**[1], the National Safeguarding Team (NHS Wales) is part of Public Health Wales and includes designated nurses, doctors and a GP lead. They support the seven health boards (HBs) and three NHS trusts in Wales. Public Health Wales has an internal safeguarding team, as do all the other health boards and trusts, which include lead safeguarding professionals. The health boards and Velindre NHS Trust also have named doctors. In Wales, the former LSCBs have become the six regional safeguarding children's boards. (Currently, there are also six regional adult safeguarding boards and, in some areas, there are plans to merge these to become adult and children boards.)

Named professional

In England, all providers of NHS, or otherwise, funded health services (including NHS trusts, NHS foundation trusts and public, voluntary sector, independent sector and social enterprises – including local authorities providing health services, i.e. 0–19 services which are CQC registered – private providers, online providers and organisations who only provide adult services) should identify a named doctor and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding children and young people, or a lead clinician where appropriate.

In the case of NHS 111, ambulance trusts and independent providers/contractors (for example, dentists), this should be a named practitioner. Each registered primary care dental setting should have access to a named dentist/professional across a larger geographical area rather than one named dentist/professional in each setting. Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place.

1 England and Wales: **Children Act 2004**
2 Northern Ireland: **The Children Order 1995**
3 Scotland: **Children Act 1995**

For independent provider organisations there should be a named nurse and doctor at national level and a named nurse and doctor at each provider location. The named midwife has knowledge and expertise of all issues associated with safeguarding children, particularly related to any specific concerns during the antenatal and early postnatal periods.

In Wales and Northern Ireland, the role of a named professional exists with similar responsibilities. In Wales, Public Health Wales, as a provider organisation, has a structure of designated and named professionals for the three regions.

In Northern Ireland, each health and social services trust has named professionals for child protection.

In Scotland, the title equivalent to the named doctor is 'paediatrician with a special interest in child protection'. Along with lead paediatricians and consultant/lead nurses, they provide clinical leadership, advice, strategic planning and are members of the child protection committee. In larger health boards there are child protection nurse advisers who support the lead nurses.

Named general practitioner

This is the GP employed by the local health care organisation to support it in carrying out its statutory duties and responsibilities for safeguarding. Activities can include: providing teaching and training to primary care, supporting practice safeguarding leads, working alongside other children and young people's safeguarding professionals locally (for example, designated professionals), working closely with adult safeguarding professionals (including named GPs for adult safeguarding), working strategically within their local health care organisation to provide child safeguarding resources for primary care.

GP practice safeguarding lead

The GP practice safeguarding lead is the GP who oversees the safeguarding work within the GP practice. The practice safeguarding lead will support safeguarding activity within the practice, work with the whole primary care team to embed safeguarding practice and ethos, provide some safeguarding training within the practice and act as a point of reference and guidance for their colleagues. Depending on practice size and structure, there may also be a practice safeguarding deputy lead. The practice should ensure that the safeguarding lead is supported in their duties, allowing protected time for these to be carried out and allowing time for additional training that the safeguarding lead is required to undertake.

Record keeping and report writing

You may see a child just once, yet your record of that visit could help save a life. Often, it is only when many unrelated factors are pieced together that practitioners can identify a case of child abuse. Good record keeping is always factual, clear, accurate, accessible and comprehensive. You should:

- write down all observations and discussions as they happen, avoid asking leading questions – allow the young person to tell their story
- carefully record your judgements and any actions or decisions taken
- include details and outcomes of health care contacts as well as follow-up arrangements
- use good practice guidance on record keeping from the NMC Code (NMC, 2018)
- use a body map to identify specific anatomical marks or injuries
- add the date and time for every entry into your records.

All information about an individual child should be held in one file, where it is accessible to all members of the team. The file should be made secure in accordance with local policy and with reference to national guidelines. All records should contain a chronology that clearly notes dates and reasons for attendance, non-attendance and significant incidents.

While oral communications do take place in all safeguarding children situations, you must always make referrals to other agencies in writing and record the outcome of each referral.

Promoting multi-agency working and communicating concerns/ information sharing

Multi-agency working is key to effective safeguarding and child protection (Sidebotham et al., 2016). Children and their families will access a range of services throughout a child's life. It is vital that practitioners work together to gain a full overview of a child's situation and have a co-ordinated approach to support.

Case reviews in each of the four UK nations emphasise the importance of information sharing and collaboration between agencies so that professionals can fully understand any risks a child may be exposed to and take appropriate action to keep them safe.

When working in a busy environment, it is important to communicate with others effectively. This is particularly important if you are sharing information that affects a child's well-being. It is important to remember that, communicating concerns/sharing information is an intrinsic part of any practitioner's role. The decisions about how much information to share, with whom and when, can have a profound impact on people's lives. You should weigh up what might happen if the information is shared against the consequences of not sharing the information.

Everyone who works with children has a responsibility to share any information that has a bearing on a child's welfare as early as possible. Practitioners working in adult services should also share any information that has an impact on the well-being of a child – for example, information about a parent's capacity to provide safe and loving care.

Follow your organisation's child protection policies and procedures as they will set out how to share information and who with. Early sharing of information is the key to providing effective early help when there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. For further guidance on sharing information see *Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers* (HM Government, 2018). This also contains a myth-busting guide.

If you are working in a multidisciplinary or multi-agency team, make sure you understand your role and the roles within your team. Discuss how you will work together to support a child or family. Always prioritise children's needs. Think about the other teams working with a child and whether there is any information you can share that will help them provide support. It is particularly important to have a comprehensive handover whenever a child starts to work with a new practitioner or a different team.

It is important that parents receive the same messages from practitioners in different agencies. If several agencies are working with a family, it might be helpful to identify a trusted key individual who will liaise with parents.

Training and education

To protect children and young people from harm, and help improve their well-being, all health care staff must have the competencies to recognise child maltreatment, opportunities to improve childhood well-being, and to take effective action as appropriate to their role (RCN, 2019). Published by the RCN, *Safeguarding children and young people: Roles and competencies for health care staff* is an intercollegiate document that provides a clear framework, which identifies the competencies required for all health care staff. Levels 1–3 relate to different occupational groups, while level 4 and 5 are related to specific roles. This version of the framework also includes specific detail for chief executives, chairs, board members (including executives, non-executives and lay members).

The RCN, as a co-producer of this intercollegiate publication, endorses the need for staff competence and emphasises the importance of maximising flexible learning opportunities to acquire and maintain knowledge and skills, drawing upon lessons from research, case studies and serious case reviews.

It is the duty of employers to ensure that those working for them clearly understand their contractual obligations within the employing organisation, and it is the responsibility of employers to facilitate access to training and education that enable the organisation to fulfil its aims, objectives and statutory duties effectively and safely.

The RCN believes that there should be:

- mandatory safeguarding children training for all nurses and health workers who may come into contact with children and young people, including ancillary and office staff
- training provided on induction, with regular update training in accordance with the intercollegiate guidance
- access to specialist post-registration safeguarding children education programmes for all professionals working in safeguarding children and selected professionals who take a lead role in safeguarding children at work
- safeguarding children training in all pre-registration nursing education, and as an integral part of student midwives' programmes.

University nursing and midwifery education programmes

A named senior lecturer should be appointed to oversee safeguarding children teaching. The training should ensure the level 2 competencies, as set out in the intercollegiate competence document (RCN, 2019), are reached for all undergraduate nursing courses.

Employer safeguarding children training programmes

Employer safeguarding children training programmes should be based on the competencies found in the intercollegiate competence document (RCN, 2019).

Supervision and support

To safeguard and be effective, practitioners need to be confident and competent, and properly supported in their role. This means having strong structures in place that provide the opportunity for robust and regular supervision that enables constructive challenge and time to reflect on practice and develop skills. Local arrangements for supervision must be robust, meet the specific needs of staff in their area and demonstrate the effective discharge of statutory duties to safeguard children and promote their welfare. All practitioners delivering safeguarding supervision should be offered training in the supervision process and should have undertaken the NSPCC child protection supervision course or its equivalent.

Where the requirement to provide supervision is part of a practitioner's job role, sufficient time must be allocated for supervision to be carried out effectively. This is particularly important when arrangements for supporting school nurses and health visitors fall outside of the named nurse role and is provided by other professionals.

The RCN believes that:

- all staff working in safeguarding children should receive regular supervision and support from a safeguarding children expert
- individual or group supervision and support should be available for anyone to access on a quarterly or more frequent basis, if necessary
- health care providers should ensure that the above is available for staff
- health care providers must communicate effectively across the organisation that supervision and support is available.

The RCN fully supports members in raising concerns regarding the care of children and young people, and the protection of their rights as individuals. If you feel compromised – for example, if training provided by your employing organisation is inadequate and you are not getting the help you need – contact RCN Direct on 0345 772 6100.

Recruitment and selection processes

England, Northern Ireland, Scotland and Wales each have specific legislation and guidance relating to safer recruitment. Across the UK, statutory guidance highlights the responsibility of those in the education, community and care sectors to have policies and procedures in place that ensure they only employ suitable people to work or volunteer with children.

Health care providers and universities should have stringent screening programmes in place as part of their recruitment and selection processes that relate to staff working with children and young people, including volunteers and nursing students. Safer recruitment is a set of practices to help make sure your staff and volunteers are suitable to work with children and young people. It is a vital part of creating a safe and positive environment and making a commitment to keep children safe from harm.

Safer recruitment should be a continuing process of improvement for every organisation whose work or services involve contact with children. Vetting, disclosure and barring checks should be carried out to ensure those employed are the right people to work or volunteer in roles that have contact with children.

Criminal records checks ensure that people aged 16 or over have nothing on their record that makes them unsuitable to work, or volunteer, in roles that have contact with children. Each nation in the UK uses a different criminal record check process, but they are all aligned and work together. A person who is barred from working with children in one nation will be barred across the UK.

If you are worried about the recruitment process in your organisation, you must use local policy to raise your concerns. In the absence of a policy, contact your RCN steward or call 0345 772 6100.

Managing allegations

Any allegation or concern that an employee or volunteer has behaved in a way that has harmed, or may have harmed, a child must be taken seriously and dealt with sensitively and promptly. Depending on the situation, an appropriate response may involve:

- the police investigating a possible criminal offence
- your local child protection services making enquiries and/or assessing whether a child is in need of support
- your organisation following the relevant disciplinary procedures with the individual concerned.

You should also make sure any children involved are given appropriate support. Your organisation should also have procedures for responding to allegations of abuse made against a child.

There are differences in the way allegations should be handled in each nation of the UK. If you are worried about the behaviour of a colleague or student, you must use local policy to raise your concerns. In the absence of a policy, contact your RCN steward or RCN Direct.

In **England**, the national guidance is *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* (Department of Education, 2018). Local safeguarding partners will also have child protection procedures.

In **Northern Ireland**, the national guidance is *Co-operating to safeguard children and young people in Northern Ireland* (Department of Health, Social Services and Public Safety, 2017). Section 7.2.10 covers allegations of abuse by a person in a position of trust.

In **Scotland**, *Safer recruitment through better recruitment* (Care Inspectorate, 2016) includes guidance on dealing with concerns or allegations about a worker's fitness to practice or harm to a user of a service.

In **Wales**, volume 5 of *Working together to safeguard people* deals with handling individual cases to protect children at risk, including managing allegations of abuse (Welsh Government, 2018).

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Websites

Briefings for health practitioners:
https://learning.nspcc.org.uk/case-reviews/learning-from-case-review-briefings

Contextual Safeguarding Network:
https://contextualsafeguarding.org.uk

RCN quality assurance

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

This guidance is for all nursing staff who are in contact with children and young people. It highlights signs of abuse and includes how to raise concerns about safeguarding/child protection issues.

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The Nine Quality Standards

This publication has met the nine quality standards of the quality framework for RCN professional publications. For more information, or to request further details on how the nine quality standards have been met in relation to this particular professional publication, please contact **publicationsfeedback@rcn.org.uk**

Evaluation

The authors would value any feedback you have about this publication. Please contact **publicationsfeedback@rcn.org.uk** clearly stating which publication you are commenting on.

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